STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056150	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Catered Manor Nursing Center	4010 N Virginia Rd. Long Beach, CA 90807

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review, the facility failed to ensure the resident, who had a change in condition (COC a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) manifested by oxygen (O2) saturation (the amount of oxygen circulating in the blood) of 86 percent ([%] a reference range for O2 saturation is 95% to 100%) on room air on [DATE], was transferred to a general acute care hospital (GACH) without a delay for one of four sampled residents (Resident 1). Resident 1 was transferred to the GACH eight hours later from the onset (start) of chest pain, shortness of breath, fluctuating (change continually) blood pressure from low to high, and desaturation (the condition of a low blood oxygen concentration). The facility failed to: 1. Ensure the Licensed Vocational Nurse (LVN 2) monitored and assessed Resident 1's vital signs ([VS] a measurements of the body's most basic functions including temperature, pulse rate, respiration rate {rate of breathing} and blood pressure) including O2 saturation rate when there was a change in resident's condition and per Registered Nurse Supervisor (RNS 1) instruction. 2. Ensure the licensed nurses informed Resident 1's physician of Resident 1's continuous oxygen desaturation ranging between 86% to 87% despite continuously receiving O2, the residents complain of a chest and abdominal (stomach) pain and feeling weak on [DATE]. 3. Ensure LVN 1 and LVN 2 made Nurse Practitioner ([NP] a nurse who has advanced clinical education and training) aware about Resident 1 was having a chest pain, abdominal pain, and was short of breath. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	These failures resulted in eight hours delay transferring Resident 1 to the GACH from the onset of Resident 1's change in condition on [DATE]. Resident 1 had low O2 saturation of 86 % while receiving O2 continuously and complained of a chest and abdominal pain. Resident 1 was transferred to the GACH on [DATE] at 7 p.m., (eight hours after Resident 1 had the oxygen desaturation to 86 % , had shortness of breath, and complained of left chest pain and left abdominal pain rated eight out of 10 on a pain scale from zero to ten (a pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible). At the GACH Resident 1 became acutely altered (sudden change) , stopped breathing and became bradycardic (a slow heart rate under 60 beats per minute) down to the 20's. Resident 1 was not spontaneously breathing and eventually had no cardiac (heart) activity. At the GACH Cardiopulmonary Resuscitation ([CPR]- emergency lifesaving procedure consisting of chest compressions combined with artificial ventilation, or mouth to mouth) was started and continued from 8:36 pm to 9:04 pm without success. Resident 1 passed away on [DATE] at 9:04 pm. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including closed fracture (a broken bone that does not pierce the skin) of the right tibia (a large bone located in the lower front portion of the leg), chest pain, hyperlipidemia (abnormal high levels of fat in the blood), hypertensive urgency (a severe elevation in blood pressure), and anemia (a blood disorder in which the blood has a reduced ability to carry oxygen). During a review of Resident 1's Order Summary (physician's orders summary) dated [DATE], the Order Summary indicated the some of the following physician's orders for Resident 1: 1. Amlodipine Besylate (blood pressure medication) 2.5 milligram ([mg] a unit of weight measurement) one tablet two times a day for angina (chest pain). Hold for systolic blood pressure ([SBP] pressure exerted when the heart beats and blood is ejected into the arteries) less than 110. 2. Chlorthalidone Tablet (blood pressure medication) 25 mg one tablet one time a day for hypertension (high blood pressure). Hold for SBP less than 110 or heart rate (HR) less than 60 beats per minute. 3. Hydralazine Hydrochloride (HCl- blood pressure medication) 25 mg one tablet as needed four times a day for SBP greater than 180. 4. Irbesartan (blood pressure medication) 300 mg one tablet one time a day for hypertension. Hold for SBP less than110 or HR less than 60. 5. Labetalol HCl 200 mg one tablet two times a day for hypertension. Hold for SBP less than 110 or heart rate less than 60. 6. Full Cardiopulmonary Resuscitation (CPR). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 was alert and oriented to self, place, time and was able to make her own medical decisions. The H&P indicated staff, nursing, and family members/care giver to call 911 (emergency number for emergency services) or go to the nearest emergency room (ER) if Resident 1 will experience chest pain, shortness of breath, loss of consciousness, change in vision, severe headache, or other alarming symptoms. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 1 was dependent on nursing staff for changing positions from sitting to standing, and transferring from a bed to the chair. The MDS indicated Resident 1 needed maximal assistance with toileting, showering, lower body dressing and putting on and off footwear. The MDS indicated Resident 1 needed moderate assistance with personal hygiene, changing positions from sitting to lying down, and lying down to sitting position. During an interview on [DATE] at 10:45 a.m., a Certified Nursing Assistant (CNA 1) stated on [DATE] between 10 a.m. and 11 a.m., he responded to a call light from Resident 1's room. CNA 1 stated he went to check on Resident 1, and observed Resident 1 having a hard time breathing, complaining of shortness of breath, holding to her chest, and verbalizing she was not feeling well and needed help. CNA 1 stated he went to report Resident 1's condition to the Licensed Vocational Nurse (LVN 1) on [DATE] at 11:00 a.m. CNA 1 stated LVN 1 went to Resident 1's room to check Resident 1's vital signs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on [DATE] at 11:05 a.m., with LVN 2, a text messages sent by LVN 1 and LVN 2 to the Nurse Practitioner ([NP] a nurse who has advanced clinical education and training), dated [DATE] at 3:12 pm, were reviewed. At 3:12 p.m. LVN 1 sent a text message to NP which indicated Resident 1's was complaining of a throat ache. The text message indicated Resident 1's O2 saturation rate was 86 % (normal oxygen saturation was 95 %-100%) on room air, body temperature was 99 degrees Fahrenheit ([F] a unit of temperature measure), blood pressure was ,d+[DATE], respirations were 22, and the pulse rate was 86. The text message indicated Resident 1's oxygen saturation went up to 94 % after administration of three liters per minute (L/min) of oxygen via nasal cannula (a device that delivers oxygen through a tube and into the nose), administered by the Registered Nurse Supervisor (RNS 1). LVN 2 stated she sent another text message right after LVN 1 indicated Resident 1's oxygen saturation was 92% on 3.0 L/min of oxygen via nasal cannula. LVN 2 stated she also sent text to the NP (both LVN 1 and LVN 2's texts were on the same thread on [DATE] at 3:12 pm text) about Resident 1's blood pressure of ,d+[DATE], pulse rate 83 and the O2 saturation rate dropped to 87 % while receiving O2 at three liters per minute via nasal cannula. LVN 2 stated Resident 1 complained of pain in the right lower abdomen and shortness of breath on [DATE] at 3 p.m. LVN 2 stated she reported Resident 1's change of condition to RNS 1 at 3 pm. LVN 2 stated RNS 1 and LVN 1 told her to monitor Resident 1's condition and if the condition worsened to send Resident 1 to the GACH. LVN 2 stated on [DATE] at 4 pm she reported Resident 1's COC to LVN 3 from incoming shift for 3 pm to 11 pm shift. LVN 2 stated on [DATE] at 5:21 pm the NP responded back by text message which indicated an order for COVID-19 (Coronavirus disease -a contagious respiratory infectious illness) test and a chest x-ray (imaging of the chest). LVN 2 stated Resident 1 was weak and desaturating. LVN 2 stated any resident with an O2 saturation below 90 % on room air with a complain of chest pain and shortness of breath should have been transferred to GACH for further evaluation and treatment. LVN 2 stated she does not know why Resident 1 was not sent to GACH when Resident 1 had a O2 saturation of 86 % on room air and 87 % on oxygen at 3.0 L /min via nasal cannula. LVN 2 stated NP was not made aware of Resident 1's complained of abdominal pain and shortness of breath. LVN 2 stated at 7 pm she spoke with LVN 3 because she noticed Resident 1's oxygen saturation was not rising above 90 percent on 5.0 L/min of oxygen via nasal cannula and the blood pressure was fluctuating . LVN 2 stated she called the Director of Nursing (DON) around 7 p.m. on [DATE] and was instructed by the DON to call 911 (emergency number) to transfer Resident 1 to the GACH. LVN 2 stated Resident 1 started to complain of chest pain during the time 911 was called. LVN 2 stated she should have call 911 immediately when Resident 1 O2 saturation was 87% while receiving oxygen at 3.0 L/min and complained of shortness of breath. A review of the text messages communication between LVN 1, LVN 2, and NP on [DATE], at 3:12 p.m., indicated the text sent to the NP indicated Resident 1 had BP of ,d+[DATE] and O2 saturation of 87%. There was no text notifying the NP of Resident 1 having a chest pain and shortness of breath. A review of Resident 1's medical record written account of resident health history) indicated the nursing staff did not document the time the resident's vital signs were taken on [DATE]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on [DATE] at 12:17 p.m., with LVN 1, the LVN 1 stated on [DATE] between 11 a.m. and 12 p.m. Resident 1 complained of weakness. LVN 1 stated he did not have time to take Resident 1's VS because he had other residents to take care of. LVN 1 stated at 1:24 p.m., he gave Resident 1 Tylenol Extra Strength (pain medication) 500 milligrams ([mg] a unit of weight measurement) for generalized body pain. LVN 1 stated at 2:30 p.m., CNA 1 came to him again and told him Resident 1 was not feeling well. LVN 1 stated the Tylenol was not working and Resident 1 looked weaker. LVN 1 stated he notified (RNS) 1 of Resident 1's condition. LVN 1 stated at 2:40 p.m., Resident 1's vital signs were taken, and the resident's temperature was 99.5 F, blood pressure was ,d+[DATE], respirations were 22, and O2 saturation was 86 % on room air. LVN 1 stated Resident 1 was placed on oxygen at 3.0 L/min via nasal cannula and the head of the bed was elevated to facilitate a better breathing. LVN 1 stated on [DATE] at 3:12 p.m., a group text message (LVN 1 and LVN 2) was sent to the NP, but NP did not respond. LVN 1 stated when Resident 1 had O2 saturation of 86% the resident's physician should have been notified and if the physician would have not responded she should have called the medical director (physician who provides guidance and leadership). Reviewed Resident 1's H&P with LVN 1 indicated to call 911 when resident experiences chest pain, shortness of breath, loss of consciousness, change in vision, severe headache, or other alarming symptoms. LVN 1 stated Resident 1 should have been transferred to a higher level of care, the GACH, from the onset of Resident 1's complains of a chest pain and O2 saturation rate of 86 % as the facility was unable to provide care to the resident. During an interview on [DATE] at 3:24 p.m., LVN 3 stated LVN 1 informed her on [DATE] (time unknown) of Resident 1's O2 saturation of 86 % on room air. LVN 3 stated she did not administer Resident 1 blood pressure medication as the resident's BP was ,d+[DATE] at 5 p.m. LVN 3 stated LVN 2 reported to her Resident 1 had chest pain on [DATE] at 4 p.m. LVN 3 stated she told LVN 2 to call 911. LVN 3 stated she did not call 911 herself because she did not want to overstep the boundaries with LVN 2, who was a charge nurse that evening shift. LVN 3 stated she should have called 911 and transfer Resident 1 to GACH when Resident 1 had O2 saturation of 86 % with receiving O2 at 3 L/min via nasal cannula, complained of shortness of breath and chest pain. During an interview on [DATE] at 12:03 p.m., RNS 1 stated on [DATE] at 2:45 p.m., LVN 1 asked for assistance with Resident 1 because the resident's O2 saturation was 86 % on room air. RNS 1 stated she was not aware of Resident 1's low blood pressure of ,d+[DATE], and oxygen saturation of 87 % on oxygen 3. 0 L/min via nasal cannula. RNS 1 stated she would have sent Resident 1 to the GACH if she had known the resident's blood pressure was low and the O2 saturation was below normal values. RNS 1 reviewed the physicians' orders and stated Resident 1 was transferred to the hospital for desaturation and chest pain on [DATE] (unspecified time). Resident 1 had a roommate Resident 2. During a review of Resident 2's Admission Record, the Admission Record indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including epilepsy (a brain condition that causes recurring seizures), pancytopenia (a significant reduction in the number of almost all blood cells), muscle weakness and colitis (swelling or inflammation of the large intestines). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 2 had the ability to make self-understood and the ability to express needs and wants. The MDS indicated Resident 2 had the ability to understand others and had clear comprehension (the ability to understand completely). The MDS indicated Resident 2 required substantial to maximal assistance from staff with toileting hygiene, showering, lower body dressing, and putting on and taking off footwear. During an interview on [DATE] at 11:20 a.m., with Resident 2 (Resident 1's roommate), Resident 2 stated Resident 1 was complaining of shortness of breath and unable to move her leg on [DATE] afternoon (cannot remember exact time). Resident 2 stated Resident 1 was having trouble breathing despite receiving oxygen. Resident 2 stated Resident 1 was having shortness of breath in the afternoon but was not transferred to a GACH until the evening of [DATE]. Resident 2 stated Resident 1 was also complaining of pain but does not know the exact location. During an interview on [DATE] at 12:03 p.m., with the DON, the DON stated she received a call from LVN 2 on [DATE] at 7 pm stating Resident 1 looked uncomfortable but was not in distress (emotional, social, spiritual, or physical pain or suffering). The DON stated she told LVN 2 to call 911 and transfer Resident 1 to GACH because Resident 1's vital signs were not at her baseline and did not consider Resident 1 to be in stable condition. The DON stated if a resident was complaining of shortness of breath, chest pain and desaturation of 86 % licensed staff should not delay the transfer of the resident to GACH. The DON stated the vital signs are monitored every shift and as needed and must be documented at the time the vital signs were taken. The facility did not provide a policy for monitoring vital sign when asked. During a review of Resident 1's Nurses Progress Notes, dated [DATE] and timed at 3:30 p.m., the Nurses Progress Notes indicated, the incoming shift (3 p.m. to 11 p.m.) was given report to continue monitoring Resident 1's O2 saturation and if the condition did not improve to send Resident 1 to GACH and inform the family. During a review of Resident 1's Nurses Progress Notes, dated [DATE] timed at 5:00 p.m., the Nurses Progress Notes indicated, Resident 1's blood pressure was fluctuating, and the O2 saturation ranged from 89 % to 91 % while receiving oxygen via nasal cannula. The Nurses Progress Note indicated Resident 1 had abdominal pain level rated five out of 10 and generalized weakness. The Nurses Progress Notes indicated Resident 1 was sent out to the hospital via 911 (time not indicated) due to desaturation and chest pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 1's Nurses Progress Note, Discharge Summary, dated [DATE] timed at 8:02 pm, the Nurses Progress Note indicated, Resident 1's had a fever, shortness of breath, fluctuating blood pressure, left sided pain, and difficulty catching her breath. The Nurses Progress Note Discharge Summary indicated Resident 1 complained of chest pain and the blood pressure dropped to ,d+[DATE], pulse 83, O2 saturation of 87 %. The Nurses Progress Note, Discharge Summary indicated when Resident 1's vital signs were rechecked the oxygen and blood pressure continued to fluctuate (change continually). The O2 saturation ranged from 87 % to 90 % on oxygen at 3.0 L/min via nasal cannula. The Nurses Progress Note Discharge Summary indicated Resident 1's blood pressure rose to ,d+[DATE] and dropped to a blood pressure of ,d+[DATE] and pulse 96 in less than 10 minutes. The Nurses Progress Note, Discharge Summary indicated Resident 1 was administered oxygen at 5.0 L/min via nasal cannula, but the oxygen saturation did not rise above 90 %. The Nurses Progress Note, Discharge Summary indicated LVN 2 called the DON for guidance and the DON informed LVN 2 to call 911 and send Resident 1 to the GACH. The Nurses Progress Note, Discharge Summary indicated on [DATE] at 7:06 pm 911 was called and Resident 1's blood pressure reading was ,d+[DATE], pulse 98, temperature 98.4, and oxygen saturation 91 percent on oxygen 5.0 L/min. The Nurses Progress Note, Discharge Summary indicated the paramedics arrived at the facility at 7:15 pm, Resident 1 was assessed, and the resident's oxygen saturation was 87% on 5.0 L/min via nasal cannula. During a review of Resident 1's Emergency Department (ED) Physician's Notes, dated [DATE], the ED Physician's Notes indicated, Resident 1 was brought to the ED at 7:42 pm by ambulance. The ED Physician's Notes indicated, Resident 1 had left chest pain and left abdominal pain level rated eight out of 10 on a pain scale rating. The ED Physician's Notes indicated Resident 1 complained of shortness of breath and on [DATE] at 7:47 p.m., Resident 1's O2 saturation was 79% on room air, the heart rate was 102 beats per minute and Resident 1 was administered oxygen with a non-rebreather mask (a device used to deliver higher concentrations of oxygen). The Physician's Notes indicated, Resident 1 had shortness of breath and became acutely altered, the resident stopped breathing and became bradycardic down to the 20's. Resident 1 was not spontaneously breathing and eventually had no cardiac activity. The ED Physician's Notes indicated a chest compressions were immediately started, and Resident 1 was intubated (a medical procedure that involves inserting a flexible plastic tube down a person's throat to open the airway and give oxygen). The CPR was continued from 8:36 p.m. to 9:04 p.m. After multiple rounds of medication and progression from asystole (when the heart has no electricity or movement and no heartbeat) to ventricular fibrillation (an abnormal heart rhythm in which the ventricles of the heart quiver) and back to asystole, a decision was made to stop CPR. The time of Resident 1's death was declared at 9:04 pm. During a review of the facility's policy and procedure titled, Change of Condition, dated 2016, the P&P indicated, Call 911 if the initial assessment indicates such action is necessary and this intervention is in accordance with existing Advance Directives (provide instructions for medical care if resident cannot communicate own wishes) / Physician Orders for Life-Sustaining Treatment ([POLST] written medical order from a physician that helps patients get the medical treatments they want). During a review of the facility's Registered Nurse Job Description, revised on [DATE], the Registered Nurse Job Description indicated, The Registered Nurses to provide accurate assessment, over-sight, and monitoring of patients for quality medical management and early detection of change in condition. Utilizes professional standards in performing clinical assessment and monitoring in accordance with scope of licensure. Recognizes and appropriately responds to emergent and significant change in condition and completes documentation as required. Identifies and acts upon unsafe situations . (continued on next page)

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